# Cumulative Impact of Mandates in Maine

Following are the estimated claim costs for the existing mandates:

- ***Mental Health*** (Enacted 1983) – The mandate applies only to group plans. It applies to all group HMO plans but does not apply to employee group indemnity plans covering 20 or fewer employees. Mental health parity for listed conditions was effective 7/1/96 but does not apply to any employer with 20 or fewer employees, whether under HMO or indemnity coverage. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.02% in 2003 but increased slightly to 3.14% in 2004.. For 2004, this broke down as 2.94% for managed care and 3.76% for indemnity plans. Although the expansion of the list of conditions for which parity is required and was not fully implemented until September 2004, it was in effect for all or most of the year for most groups. Either it had a very small impact or the impact was offset by other factors. We estimate a continuation of 2004 levels going forward. For HMO plans covering employers with 20 or fewer employees, we use half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of indemnity coverage.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31%. It then increased to 0.37% in 2001 and to 0.66% in 2002, and decreased to 0.59% in 2003. In 2004, it decreased very slightly to 0.58% despite almost full implementation of the parity requirement. The long-term decrease was probably due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 53% in 2004. The 0.58% for 2004 broke down as 0.56% for managed care plans and 0.65% for indemnity plans. This relationship reversed from the prior year and the difference does not appear to be significant. We estimate substance abuse benefits to remain at the current aggregate level of 0.58%. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent. However, this overstatement is offset by the fact that the data is an aggregate of all groups,

while the mandate applies only to groups larger than 20.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to a high of 1.51% in 2000. Since then, it decreased slightly to between 1.32% and 1.46% during 2001 to 2004. The level varies significantly between group and individual. The variation between HMOs and indemnity plans has decreased to an insignificant level. For 2004, the percentages for group plans were 1.40% for HMO plans and 1.36% for indemnity plans with an aggregate of 1.39%. For individual plans, it was 0.65% for HMO plans, and 0.62% for indemnity plans with an aggregate of 0.62%. We estimate the aggregate levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.7% in 2002, decreasing slightly to 0.67% in 2004, which may reflect increasing utilization of this service followed by a leveling off. This figure broke down as 0.65% for HMO plans, 0.71% for indemnity plans. We estimate 0.67% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual.

Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would

be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small employer groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- Licensed Pastoral Counselors and Marriage & Family Therapists (Enacted 2005) – This mandate requires coverage of **licensed pastoral counselors and marriage & family therapists**. Our report indicated no measurable cost impact for this coverage.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

| Year Enacted | Benefit | Type of Contract Affected | Est. Maximum Cost as % of Premium | |
|---|---|---|---|---|
| | | | Indemnity | HMO |
| 1975 | **Maternity** benefits provided to married women must also be provided to unmarried women. | All Contracts | 0[1] | 0[1] |
| 1975 | Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician. | All Contracts except HMOs | 0.10% | -- |
| 1975 | Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects. | All Contracts except HMOs | 0[1] | -- |
| 1983 | Benefits must be included for treatment of **alcoholism and drug dependency**. | Groups of more than 20 | 0.58% | 0.58% |
| 1975<br>1983<br>1995<br>2003 | Benefits must be included for **Mental Health Services**, including psychologists and social workers. | Groups of more than 20 | 3.76% | 2.94% |
| | | Groups of 20 or fewer | -- | 1.47% |
| 1986<br>1994<br>1995<br>1997 | Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits. | Group | 1.39% | 1.39% |
| | | Individual | 0.62% | 0.62% |
| 1990<br>1997 | Benefits must be made available for screening **mammography**. | All Contracts | 0.67% | 0.67% |
| 1995 | Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes. | All Contracts | 0.02% | 0.02% |
| 1995 | Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products. | All Contracts | 0.01% | 0.01% |
| 1996 | Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Prenatal Care." | All Contracts | 0 | 0 |
| 1996 | Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training. | All Contracts | 0.20% | 0.20% |
| 1996 | Benefits must be provided for **screening Pap tests**. | Group, HMOs | 0.01% | 0 |
| 1996 | Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician. | Group managed care | -- | 0.10% |
| 1997 | Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient. | All Contracts | 0.07% | 0.07% |
| 1998 | Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS. | All Contracts | 0.30% | 0.30% |
| 1998 | Coverage required for **prostrate cancer screening**. | All Contracts | 0.07% | 0 |

| | | | | |
|---|---|---|---|---|
| 1999 | Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers. | All Managed Care Contracts | -- | 0.16% |
| 1999 | Prescription drug must include **contraceptives**. | All Contracts | 0.80% | 0.80% |
| 1999 | Coverage for **registered nurse first assistants**. | All Contracts | 0 | 0 |
| 2000 | Access to **clinical trials**. | All Contracts | 0.46% | 0.46% |
| 2000 | Access to **prescription drugs**. | All Managed Care Contracts | 0 | 0 |
| 2001 | Coverage of **hospice care services** for terminally ill. | All Contracts | 0 | 0 |
| 2001 | Access to **eye care**. | Plans with participating eye care professionals | 0 | 0.04% |
| 2001 | Coverage of **anesthesia** and facility charges for certain **dental** procedures. | All Contracts | 0.05% | 0.05% |
| 2003 | Coverage for **prosthetic devices** to replace an arm or leg | Groups >20 | 0.03% | 0.03% |
| | | All other | 0.08% | 0.08% |
| 2003 | Coverage of licensed clinical professional counselors | All Contracts | 0 | 0 |
| 2005 | Coverage of licensed pastoral counselors and marriage & family therapists | All Contracts | 0 | 0 |
| | **Total cost for groups larger than 20:** | | **8.52%** | **7.82%** |
| | **Total cost for groups of 20 or fewer:** | | **4.23%** | **5.82%** |
| | **Total cost for individual contracts:** | | **3.45%** | **3.48%** |